# BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
# POLICIES AND PROCEDURES MANUAL

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| **Chapter: 3** | **Member Rights and Responsibilities** | | |
| **Section: 8** | **Customer Rights and Protections** | | |
| **Topic: 7** | **Appeals and Grievance Procedural Processes** | | |
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## Policy

It is the policy of Bay Arenac Behavioral Health Authority (BABHA) to implement the Michigan Department of Health and Human Services (MDHHS) technical requirements for appeals and grievances in the mental health service delivery system. These documents are herein incorporated into this policy by reference.

## Purpose

The purpose of this policy and procedure is to comply with requirements of the Medicaid Specialty Supports and Services 1915 (b)/(c) waiver program and MDHHS-Community Mental Health Services Program (CMHSP) contract.

## Education Applies to

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
  ☐ Policy Only ☐ Policy and Procedure
☐ Other:

## Definitions

Adequate Notice: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. Notice is provided to the beneficiary at the same time an adverse benefit determination takes effect or at the time of the signing of the individual plan of services/supports. The provider(s) will also receive notice of this adverse benefit determination, if applicable.

Advance Notice: Written statement advising the beneficiary of an Adverse Benefit Determination to reduce, suspend or terminate services currently provided, which must be mailed to the beneficiary at least ten (10) calendar days prior to the proposed date the adverse benefit determination is to take effect. The provider(s) will also receive advance notice of this adverse benefit determination.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within 72 hours from the date of receipt of a request for an expedited service authorization.
- Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning meeting and as authorized by the PIHP.
- Failure of the PIHP to act within 30 calendar days from the date of a request for a standard appeal.
- Failure of the PIHP to act within 72 hours from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within 90 calendar days of the date of the request.

Alternative Dispute Resolution: MDHHS process for providing an administrative forum for adverse benefit determinations in appeal by applicants/recipients of public behavioral health services who are not covered by the federal standards related to a State Fair Hearing (Medicaid/Healthy Michigan).

Appeal: A customer's request for a review of an adverse benefit determination.

Individual/Individual served/Beneficiary/Customer/Enrollee: A person that is either a current recipient of, or desiring eligibility determination for, behavioral health funded by the CMHSP.

Family Support Subsidy: A program through MDHHS that provides financial assistance to families that include a child with severe developmental disabilities. The intent is to help make it possible for children with developmental disabilities to remain with or return to their birth or adoptive families. Families are able to use this money for special expenses incurred while caring for their child.

Grievance: An individual's dissatisfaction about any matter related to a service, other than an adverse benefit determination as defined above, and does not involve a recipient rights complaint. Possible subjects of grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the individual served.

Informal Dispute Resolution: A process by which an individual served may resolve grievances or appeals with the treating staff, the supervisor or administrator prior to using the formal appeals or grievance process and/or Medicaid Fair Hearing/Dispute Resolution Process.

Inquiry: A request for assistance and/or information regarding behavioral health services, benefits, and/or resources.

Legal representative: An individual who has legal authority to act on an individual's behalf (such as a guardian or durable power of attorney).

Michigan Department of Health and Human Services (MDHHS) State Medicaid Fair Hearing: An impartial review by a MAHS - LARA Administrative Law Judge of a decision regarding public behavioral health and/or substance use disorder services specific to an individual served.

An individual completes the necessary process to access this service, with either Pre-Paid Inpatient Health Plan (PIHP) or the CMHSP.

<u>Person-Centered Plan (PCP) (specifically for behavioral health services)</u>: A plan for treatment that includes clearly stated goals, measurable objectives, and methodology that specifies the amount, scope, duration, and intensity of services to be provided. The plan is derived from an assessment of the individual's condition, the individual's wishes and desires, natural supports, and community resources and the PCP also needs to take health and safety factors into consideration.

<u>Second Opinion</u>: A request for the opinion from a second qualified person who was not involved in the initial determination regarding such things as eligibility, treatment plans, amount, scope and duration of authorized services, etc.

<u>Unreasonable delay</u>: Services beginning more than fourteen (14) calendar days beyond the start date agreed upon during the person-centered planning process and as authorized.

# NOTICES AND APPEALS PROCEDURE

## REQUIREMENTS:

It is the policy of BABHA that all consumers/recipients have the right to a fair and efficient process for resolving complaints regarding their services and supports that are managed and/or delivered by BABHA. Recipients of, or applicants for public behavioral health services may pursue their complaints within multiple options, including:

- Office of Recipient Rights
- CMHSP Second Opinion Process
- Informal Conflict Resolution
- Appeal Process – Including Expedited “Fast” Appeals
- MDHHS State Fair Hearing (if Medicaid) (in relation to adverse benefit determinations)
- MDHHS Alternative Dispute Resolution (if not a Medicaid recipient and local processes have been exhausted) (in relation to adverse benefit determinations)
- BABHA Grievance Process (for both Medicaid and Non-Medicaid consumers) (for all other issues that are not in relation to adverse benefit determinations or recipient rights)
- Behavioral Health Mediation Services (see policy C03-S08-T10)

Individuals served and/or legal representatives will receive written and/or verbal education about all of the available options throughout all stages of treatment, including telephone screening by BABHA Access Staff, intake evaluations, interim treatment planning, annual planning meetings and as requested. The information will be available in a language format understood by the individual. Individuals served and legal representatives will also be informed that no retaliation will occur if they access any of the above processes.

## Standards

1. All federal and state appeal and grievance requirements and regulations will be followed, including but not limited to: timelines, documentation content, notice requirements, appeal acknowledgment letters, appeal disposition letters, and appeal logs. If BABHA is unable to process an appeal or grievance within the standard timeframes for an appropriate reason, a letter requesting an extension will be sent to the individual served/responsible party before the standard timeframe expires.

2. BABHA will utilize the Electronic Health Record system to track notices that are sent to individuals regarding adverse benefit determinations. All individuals served will receive a PCP Adequate Notice with each new PCP and each PCP addendum.

   a. BABHA Staff will use standardized templates for Medicaid Adequate Notices, Medicaid Advance Notices, Non-Medicaid Advance Notices, Non-Medicaid Adequate Notices, Appeal Acknowledgment Letters, and Appeal Disposition Letters.

## Notices

1. BABHA will send individuals served/their legal representatives a timely adequate notice if a decision is made to deny services based upon overall eligibility, service eligibility, unit amount (authorized less than requested), claim payments or an ineligibility determination following a face-to-face assessment by BABHA or a BABHA contract provider. The provider(s) will also receive notice of this adverse benefit determination, if applicable.

   a. The denial will be reviewed by a qualified and credentialed professional (LMSW, MD/DO, licensed psychologist, limited licensed psychologist, and licensed professional counselor or others with acceptable qualifications) dependent on the service in question.

2. BABHA will ensure individuals served receive a timely (at least 10 calendar days PRIOR to the effective date of the adverse action) advance notice if a decision is made through BABHA utilization management that results in an adverse benefit determination toward services an individual is receiving (suspension, reduction, or termination). The provider will also receive advance notice of this adverse benefit determination.

## Appeal Options

Individuals served or legal representatives may request a local BABHA appeal whenever a service is denied, suspended, reduced, or terminated, whenever there is an unreasonable delay of the start of services, when the adverse benefit determination is taken at initial eligibility determination as an applicant, or when the adverse benefit determination is outside of the treatment planning process for an established individual served. All appeals will be managed by BABHA Recipient Rights/Customer Services (RR/CS) Department.

BABHA will:

1. Process all second opinion requests made by individuals regarding overall ineligibility denials through access or face-to-face assessments.

2. Process all appeals regarding all eligibility denials, BABHA utilization management decisions, in addition to all adverse benefit determination decisions made by BABHA contract providers.

3. Prepare cases and appear for MDHHS Medicaid Fair Hearings due to decisions made or notices sent by BABHA or its contract providers. Note: If a BABHA provider obtains information about a filed Medicaid Fair Hearing Request, the provider must inform BABHA.

    a. BABHA contract providers must notify BABHA of all Medicaid Fair Hearing requests and provide copies of the hearing request, notices, dismissals or judge’s

decisions and any requested documentation for consultative and review purposes.

**Notices (Adverse Benefit Determination)**

1. BABHA and its contract providers are required to provide individuals served with an adequate notice when decisions regarding services are made through the Person-Centered Planning (PCP) process. Individuals served/their legal representatives will be notified that they have the right to receive copies, free of charge, of all records relevant to the claim of benefits.

2. BABHA will provide an adequate notice to individuals if a decision is made to deny psychiatric hospitalization through the local CMHSP Emergency Services Department.

3. BABHA and its contract providers will send an advance notice to individuals served if decisions made outside of the Person-Centered Planning process result in an adverse benefit determination toward an individual’s services and will provide a PCP adequate notice to individuals served upon completion of a PCP or PCP addendum.

    a. The BABHA contractors must use a standardized notice template provided by BABHA.
    b. The BABHA RR/CS Department is the contact location for any individual’s appeals, grievances, or requests for second opinions.
    c. The primary case coordinator, case-manager or supports coordinator will mail the advance notice to the individual served at least ten (10) calendar days prior to the adverse benefit determination effective date.
    d. The BABHA Access Department will provide notice to individuals served within fourteen (14) calendar day when authorization or service decisions are made that deny or limit services.
    e. The primary case coordinator will provide adequate notice at the time that the PCP is signed by the individual served or legal representative.
    f. Under certain circumstances Advance Notice is not required and Adequate Notice

may be issued not later than the date of the adverse benefit determination. The exceptions that allow an Adequate notice are:

i. BABHA or contract provider has obtained factual information confirming the death of the individual served.
ii. BABHA has received a written statement signed by the individual or legal representative that states that he/she no longer wishes to receive services. Or the individual served or legal representative gives information that requires termination or reduction of services and he/she understands that this must be the result of supplying the information.
iii. The individual served has been admitted to an institution where he/she is ineligible under Medicaid for further services.
iv. The individual's whereabouts are unknown and the post office has returned mail sent to the individual served by BABHA indicating no forwarding address.
v. BABHA has established the fact that the individual has been accepted for Medicaid services by another community mental health agency.
vi. The individual's physician prescribes a change in the level of medical care (this would include the physician's decision to discharge the individual).

g. In the event that an individual served requests a local appeal within ten (10) calendar days of the date of the adverse benefit determination, BABHA will not reduce, suspend or terminate services until a decision is made in response to the local appeal. If BABHA's adverse benefit determination is supported by the local appeal decision process, BABHA may seek reimbursement from the individual served for the cost of any services provided to the individual including this period of time, up to the individual's ability to pay.
h. The individual may withdraw a request for a Fair Hearing by submitting a Hearing Withdrawal Form. Individuals served may obtain this form by contacting BABHA RR/CS Department.

**Appeals**

1. BABHA will process all second opinion requests made through emergency services for denials of inpatient psychiatric hospitalizations. BABHA will have a policy depicting the process, including Adequate Notices that should be immediately given to the individual upon the decision to deny inpatient psychiatric hospitalization

2. The BABHA RR/CS Department will process all appeal requests made by an individual served due to adverse benefit determinations taken by BABHA or one of its contractors. The CMHSP will follow all regional, state, and federal standards and regulations, including but not limited to, timelines [normal review of thirty (30) calendar days and expedited or "fast" review of seventy-two (72) hours], appeal acknowledgment letters (within 5 business days), and appeal disposition letters within thirty (30) calendar days. The appeal process will include BABHA and contract provider supervisory staff at various levels of authority and who have the appropriate credentials for the scope of the service or the issue in question. This reviewer should not have been involved in the original adverse benefit determination decision. If a request for an expedited resolution of an appeal is denied, BABHA's RR/CS Department will:
   - Transfer the appeal to the standard resolution time frame.
   - Initiate reasonable efforts to provide prompt oral notice of the denial.
   - Provide follow-up written notice to the individual within 2 calendar days
   - Resolve the appeal as expeditiously as the individual's health condition requires, but not to exceed 30 calendar days.

3. Individuals served are given 60 calendar days from the date of the notice of action to request a local appeal.

4. BABHA will prepare cases and appear for MDHHS Medicaid Fair Hearings in relation to notices sent by BABHA or those related to their contract providers.

5. BABHA's RR/CS Department will accurately maintain a record of the appeal/grievance including but not limited to a general description of the appeal/grievance; date received; date of each review; resolution at each level; date of resolution at each level and the name

of the person for whom the appeal/grievance was filed.

6. Oral requests for a local appeal of an action are accepted and confirmed in writing (unless the individual requests expedited resolution for which oral response is allowed).

7. Individuals served shall be provided access to, free of charge, their case file and applicable documentation used to determine the denial, reduction, suspension, or termination of their services.

**Denial of Hospitalization**

1. If a potential or individual actively served is screened for high acuity services and is denied access to a psychiatric inpatient hospital, any or all of the following processes may be utilized:
   a. Request a Second Opinion
      i. If the pre-admission screening unit or children's diagnostic and treatment service of BABHA denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child will be offered the option to request a second opinion from the BABHA CEO.
      ii. The request for the second opinion shall be processed in compliance with Sections 409 (4), 498e (4) and 498h (5) of the Michigan Mental Health Code (MMHC). If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the CEO, in conjunction with the medical director, shall make a decision based upon all clinical information available within one business day.
   b. File a Recipient Rights Complaint
      i. If the request for a second opinion itself is denied, the individual or someone on his/her behalf may file a rights complaint with the BABHA's RR/CS Department for processing under Chapter 7A of the MMHC.
      ii. If the initial request for inpatient admission is denied, and the individual is a current recipient of other Agency services, the individual or someone on

his/her behalf, may file a rights complaint alleging a violation of his/her right to treatment suited to condition.

iii. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current recipient of other Agency services, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the BABHA RR/CS Department for processing under Chapter 7A of the MMHC.

c. Appeal (see Local Appeals Resolution section)

d. MDHHS Level

i. Medicaid Fair Hearing (see Fair Hearing process section): for Medicaid beneficiary appeals of adverse benefit determinations that impact Medicaid/Healthy Michigan covered services.

ii. MDHHS Alternative Dispute Resolution (see this section): for appeals on adverse benefit determinations that impact non-Medicaid covered services.

2. If a second opinion is requested, the CEO or his/her designee will be responsible for arranging for an evaluation by a psychiatrist, other physician, or licensed psychologist within seventy-two (72) hours, excluding Sundays and legal holidays.
3. If an individual is assessed and found not to be clinically appropriate for inpatient psychiatric hospitalization, the Emergency Services Department will provide appropriate referral service if that was not accomplished after the initial pre-admission screening.

**Denial of Access to any Services for Individuals not receiving any Agency Services**

1. Any or all of the following processes may be utilized:

a. Request for a Second Opinion – If an initial applicant for behavioral health services is denied such services by BABHA, the applicant or his/her guardian, or the applicant's parent in the case of a minor, shall be informed of their right to request a second opinion from the BABHA CEO. The request shall be processed in compliance with Section 705 of the MMHC and will be resolved within five (5) business days.

b. Rights Complaint – The applicant or his/her guardian may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing

as a recipient of behavioral health services. RR/CS Department staff may assist the individual served in completing the BABHA Grievance/Dispute Form. The applicant or his/her guardian may, however, file a rights complaint if the request for a second opinion is denied by the Agency.

c. Appeal – See Local Appeals Resolution process section.

d. MDHHS Level

   i. Medicaid Fair Hearing (see Medicaid Fair Hearing process section): for Medicaid beneficiary appeals of adverse benefit determinations that impact Medicaid/Healthy Michigan covered services.
   MDHHS Alternative Dispute Resolution (see this section): for appeals of adverse benefit determinations that impact non-Medicaid covered services.

**<u>Denial or Termination of Family Support Subsidy</u>**

1. BABHA will make available copies of blank applications forms, parent report forms, the forms for changed family circumstances, and appeal forms
2. BABHA staff will review all applications for the Family Support Subsidy and promptly approve or deny the application.
3. BABHA staff will provide written notice to the applicant of the adverse benefit determination.
4. If the application is denied due to insufficient information on the application form or the required attachments, BABHA staff shall identify the insufficiency in the written notification.
5. If an application for a Family Support Subsidy is denied or terminated by BABHA, the parent or legal guardian will be informed of his/her right to request an appeal.
6. The request for appeal must be submitted in writing within two (2) months of the notice of termination or denial and addressed to the BABHA CEO. If assistance with this request is desired and requested, BABHA staff will provide it.

**<u>Behavioral Health Services Grievance Procedure</u>**

1. BABHA will process all grievances for BABHA, and all contract providers.

a. All grievances for the public behavioral health system will be forwarded to the BABHA RR/CS Department.
b. BABHA programs and all BABHA contracted providers will provide assistance as requested by the PIHP during the research and resolution process of the grievance investigation.

2. All behavioral health grievances will be logged into the electronic health record. This record must contain at a minimum: a general description of appeal/grievance; date received; date of each review; resolution at each level; date of resolution at each level; name of person for whom appeal/grievance was filed

3. All individuals served who file a grievance will receive an acknowledgment letter within five (5) business days.

4. All individuals served will receive a disposition letter within two (2) calendar days of the outcome or resolution of their grievance. The grievance must be resolved within a designated period of time not to exceed ninety (90) calendar days.

**<u>Informal Resolution of Customer Complaints</u>**

1. An individual served or legal representative who does not wish to participate in the formal appeal and grievance process may request informal resolution of a complaint or dissatisfaction with a service. This may be requested verbally or in writing to the program director or service director. Individuals or legal representatives making such a request must be made aware of their rights to the local appeal and grievance resolution process if they want to go beyond the informal process.
2. The program supervisor, or service director will document the request, arrange a time to discuss the concern, and attempt to resolve the issue. Every effort should be made to resolve the issue within seven (7) working days. The resolution will be documented in writing and forwarded to the complainant.

3. If the complainant is dissatisfied with the resolution of the informal resolution process staff will provide information about the formal appeal and grievance process.

## Medicaid Fair Hearing Process

1. BABHA will inform all Medicaid/Healthy Michigan beneficiaries of their right to the Fair Hearing process. Information regarding Medicaid Fair Hearings will be provided on adequate and advance notices, agency brochures, BABHA's website (www.babha.org) and in the consumer handbook. Medicaid consumers are informed of their right to access to the State Fair Hearing process for appeal of actions, including the 120 calendar day deadline (from the date of notice of an action) for filing a request.
2. BABHA shall not limit or interfere with the individual's right to make a request for a hearing, and BABHA's RR/CS Department will assist individuals served in submitting a request for a Medicaid Fair Hearing.
3. Beneficiaries must exhaust the local appeals system before Medicaid Fair Hearings can occur as they cannot occur simultaneously. Therefore, a Medicaid Fair Hearing cannot be requested until after receiving notice that the adverse benefit determination is upheld.
4. If BABHA fails to follow the notice requirements, then the beneficiary may request a Medicaid Fair Hearing and BABHA's RR/CS Department may assist individuals served in submitting a request for a Medicaid Fair Hearing.

## Attachments

N/A

## Related Forms

1. BABHA Phoenix CS Module Log

## Related Materials (Located in EHR)

1. BABHA Appeals and Grievance Management Plan
   (Dated 12/1/05)
2. BABHA Medicaid Adequate Notice of Adverse Benefit Determination Forms
3. BABHA Medicaid Advance Notice of Adverse Benefit Determination Forms – Templates per contract
4. BABHA Non-Medicaid Adequate Notice of Adverse Benefit Determination Forms - Templates per contract
5. BABHA Non-Medicaid Advance Notice of Adverse Benefit Determination Forms - Templates per contract
6. BABHA grievance acknowledgment letter or Templates per contract
7. BABHA grievance disposition letter or Templates per contract
8. BABHA appeal acknowledgment letter or Templates per contract
9. BABHA appeal disposition letter or Templates per contract

## Reference/Legal Authority

1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P.6.3.2.1: The Appeal and Grievance Resolution Processes Technical Requirement,
2. MDHHS Appeal and Grievance Resolution Processes Technical Requirement, Attachment P6.3.2.1R.

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| SUBMISSION FORM | | | | |
|---|---|---|---|---|
| **AUTHOR/ REVIEWER** | **APPROVING BODY/COMMITTEE/ SUPERVISOR** | **APPROVAL /REVIEW DATE** | **ACTION (Deletion, New, No Changes, Replacement or Revision)** | **REASON FOR ACTION - If replacement list policy to be replaced** |
| Kim Cereske | Kim Cereske | 7/14/10 | Revision | Triennial Review-updated language, “Mental Health and Substance Use Disorder service delivery system” added to policy statement, no changes to policy intent/procedures |
| Kim Cereske | Kim Cereske | 6/30/10 | Revision | Corrected grammar in policy statement. Combination of two policies and TRs and updated language/acronyms |
| Melissa Prusi | Christopher Pinter | 12/15/15 | Revision | Added CEO name only |
| Melissa Prusi | Christopher Pinter | 6/30/16 | Revision | Triennial Review-Updated titles and acronyms |
| Melissa Prusi | Christopher Pinter | 05/09/2017 | Revision | DHHS/PIHP Contract: 6.3.1.1 Technical Requirement. UPDATE THROUGHOUT "Action" to "Adverse Benefit Determination." Amend "Action" definition to "Adverse Benefit Determination" Update "45 days" to "30 days". Update "3 days" to "72 hours". |
| Melissa Prusi | Christopher Pinter | 10/27/2017 | Revision | DHHS/PIHP Contract Technical Requirement Updates throughout. |
| Melissa Prusi | Christopher Pinter | 3/5/18 | Revision | Changes made to meet CARF standard and DMC standards |
| Melissa Prusi | Christopher Pinter | 06/03/2019 | Revision | Annual and Triennial review. Minor updates. |
| Melissa Prusi | Christopher Pinter | 10/1/2021 | No changes | Triennial review-no changes |
| Melissa Prusi | Christopher Pinter | 09/15/2023 | Revision | Changes made to address DMC standards/CAP |
| Melissa Prusi | Christopher Pinter | 12/10/2024 | Revision | Triennial review-appeals information added under # 7 on page 11. |